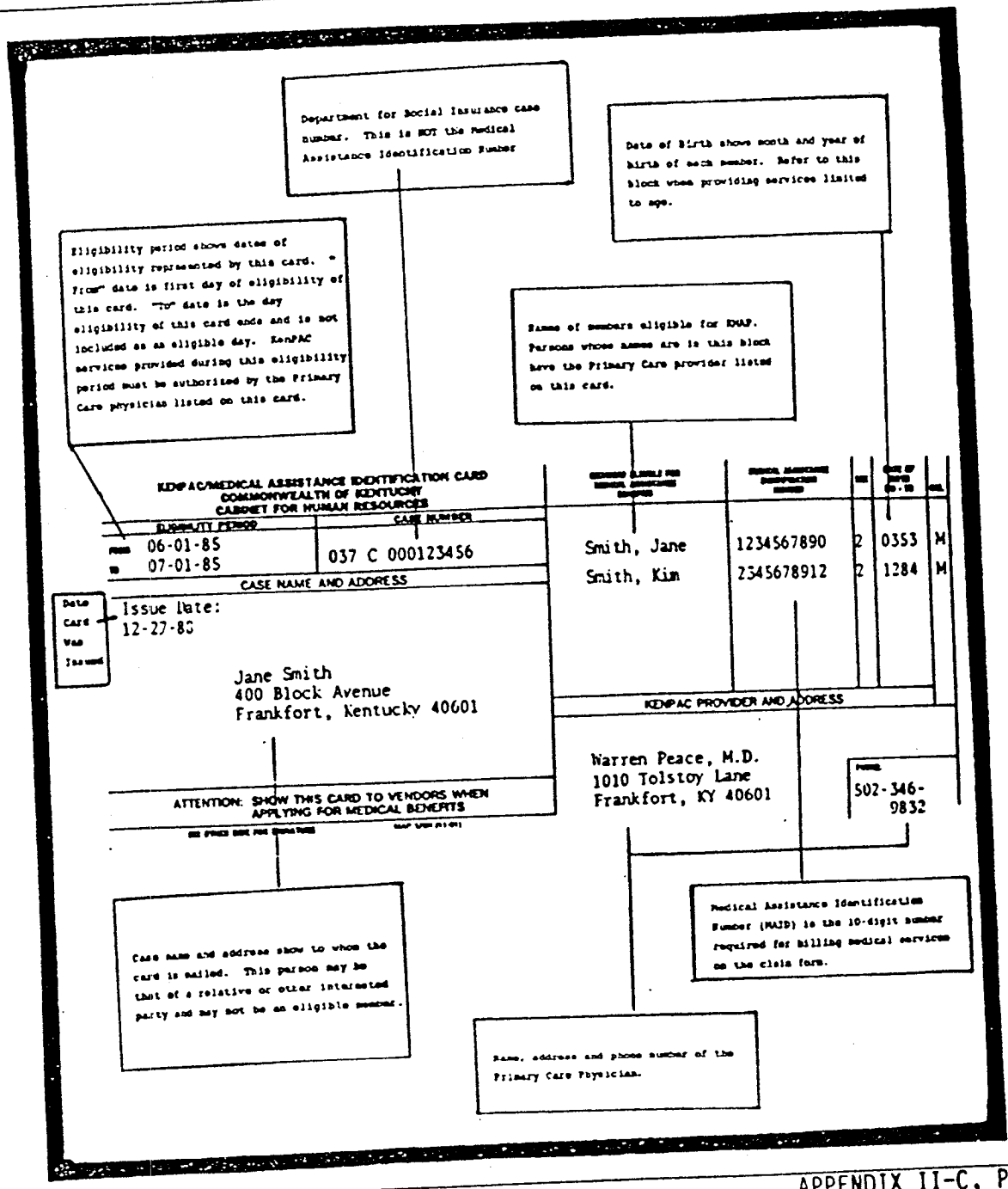
NEW FORM



CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



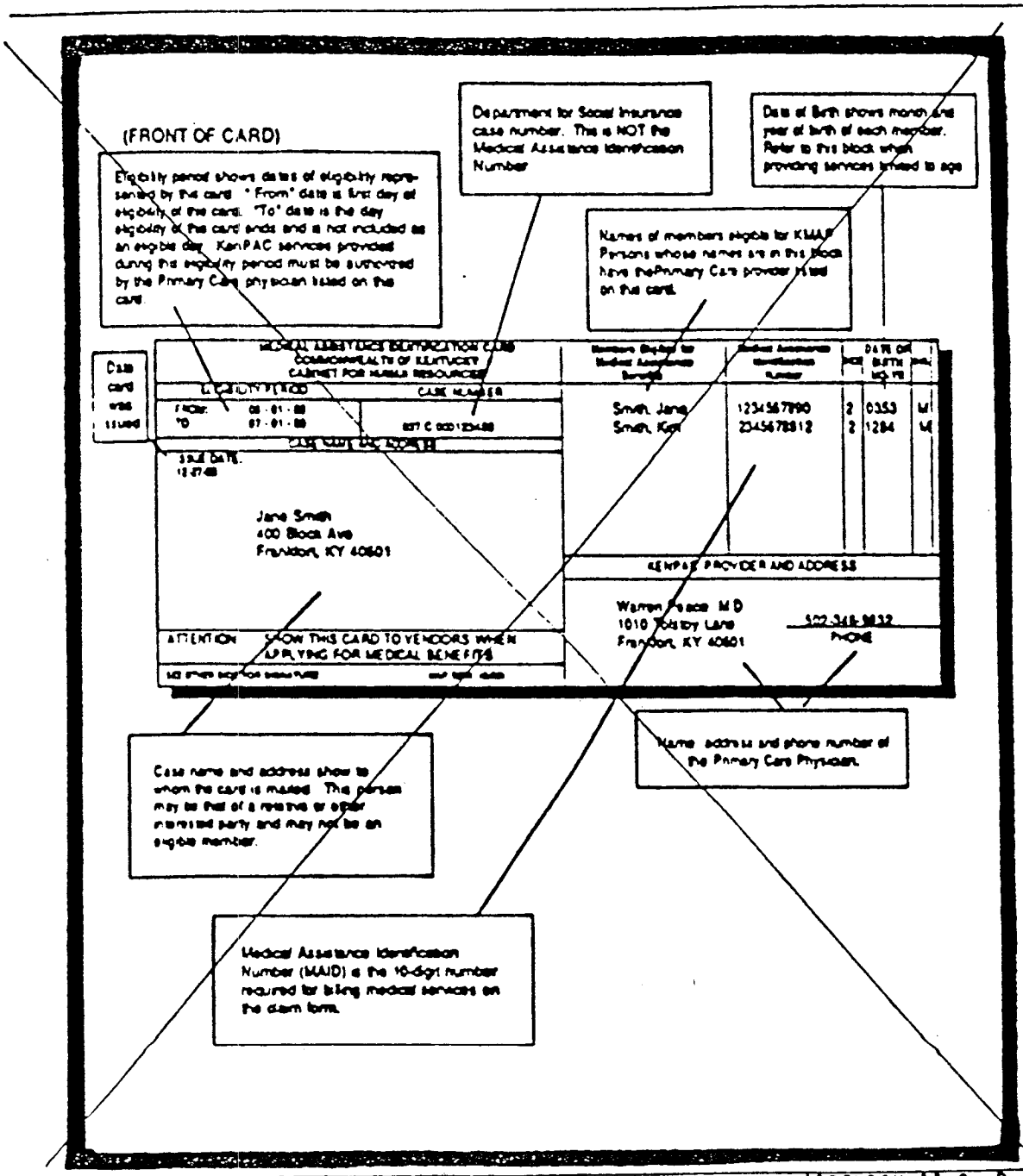
# KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM



CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

## KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM



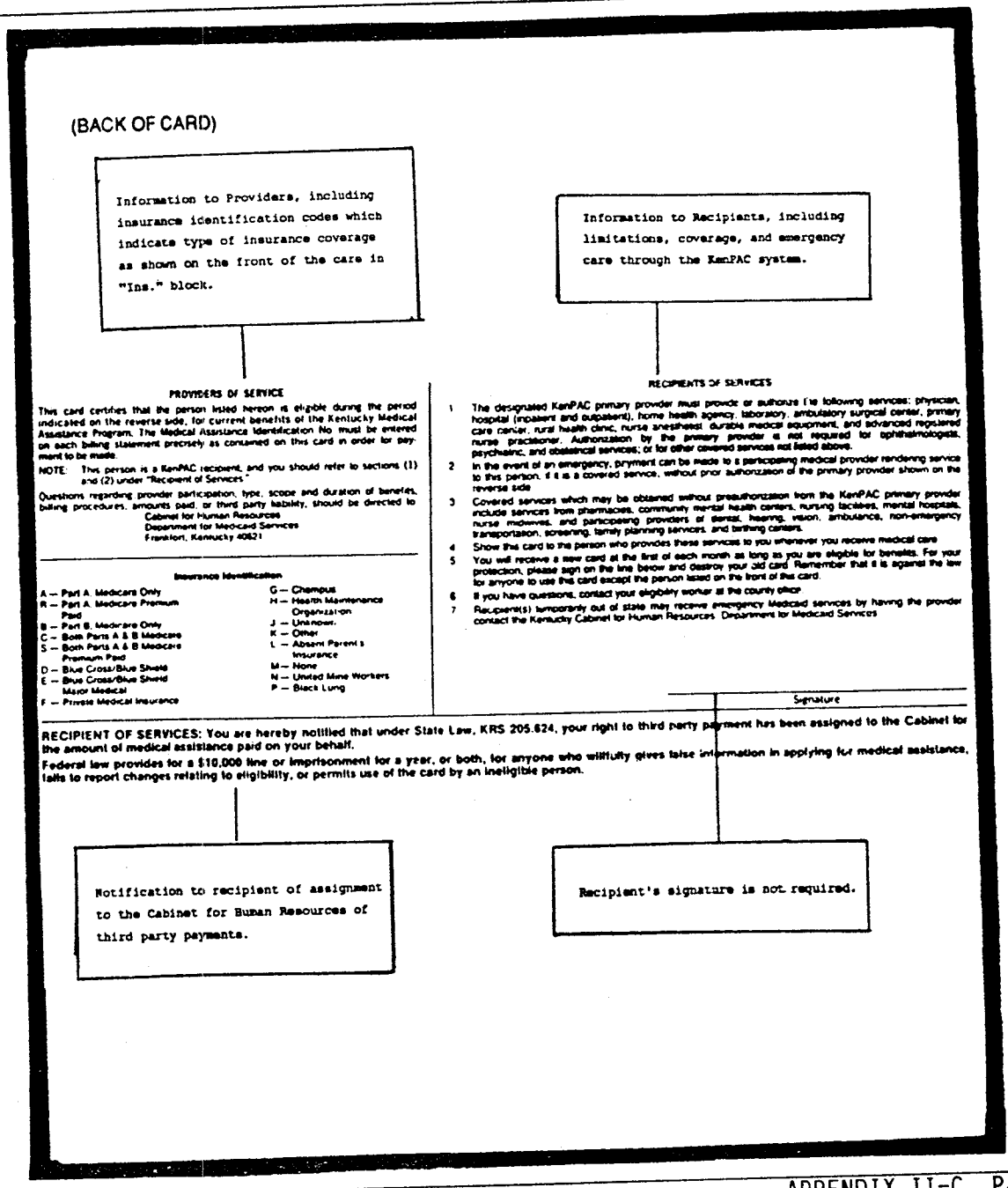
NEW FORM



CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



## KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM



(BACK OF CARD)

Information to Providers, including insurance identification codes which indicate type of insurance coverage as shown on the front of the care in "Ins." block.

Information to Recipients, including limitations, coverage, and emergency care through the KenPAC system.

**PROVIDERS OF SERVICE**

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to sections (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:
Cabinet for Human Resources
Department for Medicaid Services
Frankfort, Kentucky 40621

**Insurance Identification**

A — Part A. Medicare Only
R — Part A. Medicare Premium Paid
B — Part B. Medicare Only
C — Both Parts A & B Medicare
S — Both Parts A & B Medicare Premium Paid
D — Blue Cross/Blue Shield
E — Blue Cross/Blue Shield Major Medical
F — Private Medical Insurance
G — Champus
H — Health Maintenance Organization
J — Unknown
K — Other
L — Absent Parent's Insurance
M — None
N — United Mine Workers
P — Black Lung

**RECIPIENTS OF SERVICES**

1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital (inpatient and outpatient), home health agency, laboratory, ambulatory surgical center, primary care center, rural health clinic, nurse anesthetist, durable medical equipment, and advanced registered nurse practitioner. Authorization by the primary provider is not required for ophthalmologists, psychiatric, and obstetrical services; or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.
4. Show the card to the person who provides these services to you whenever you receive medical care.
5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient(s) temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

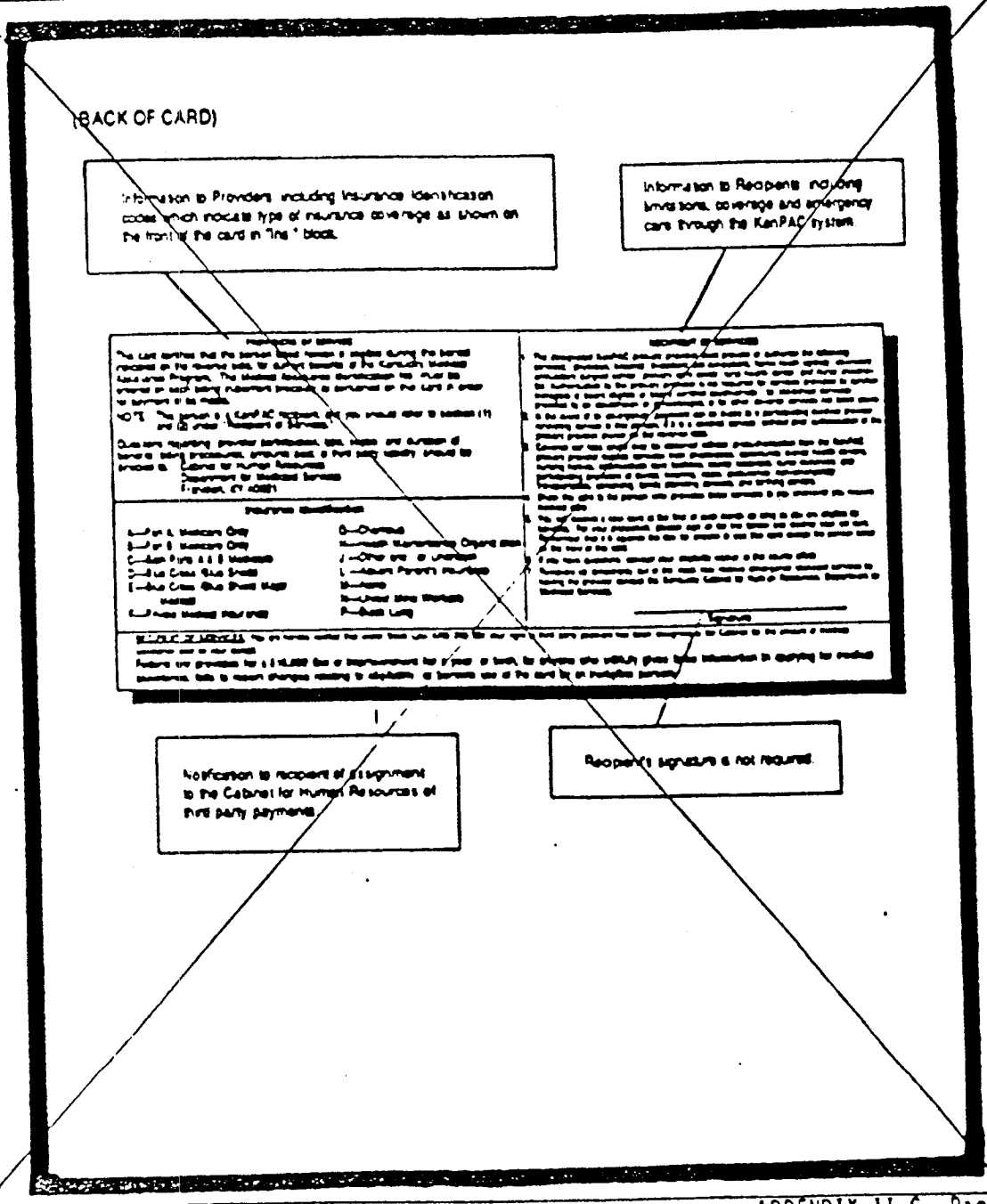
**RECIPIENT OF SERVICES:** You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM



NEW FORM



CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



## CERTIFICATION ON LOBBYING (MAP-343 A)

MAP-343 A
(11/91)

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

NEW FORM

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

## PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 3/91)

Kentucky Medicaid Program

Provider Information

1. _____ (Name) _____ (County)

2. _____ (Location Address, Street, Route No, P.O. Box)

3. _____ (City) (State) (Zip)

4. _____ (Office Phone# of Provider)

5. _____ (Pay to, In care of, Attention, etc. If different from above address.)

6. _____ Pay to address (If different from above)

7. Federal Employee ID No. _____

8. Social Security No. _____

9. License No. _____

10. Licensing Board (If applicable): _____

11. Original license date: _____

12. Kentucky Medicaid Provider No. (If known) _____

13. Medicare Provider No. (If applicable) _____

14. Practice Organization/Structure: _____ (1) Corporation
____ (2) Partnership ___(3) Individual
____ (4) Sole Proprietorship ___ (5) Public Service Corporation
____ (6) Estate/Trust ___ (7) Government/Non-Profit

15. Are you a hospital based physician (salaried or under contract by a hospital)? ___ yes ___ no
Name of hospital(s) _____

1

## PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____

2. _____
Street Address, P.O. Box, Route Number (In Care of, Attention, etc.)

3. _____ _____ _____
City State Zip Code

4. _____
Area Code Telephone Number

5. _____
Pay to, In Care of, Attention, etc. (If different from above)

6. _____
Pay to Address (If different from above)

7. Federal Employer ID Number: _____

8. Social Security Number: _____

9. License Number: _____

10. Licensing Board (If Applicable): _____

11. Original License Date: _____

12. KMAP Provider Number (If Known): _____

13. Medicare Provider Number (If Applicable): _____

14. Provider Type of Practice Organization:

| | | |
|---|---|---|
| ☐ Corporation (Public) | ☐ Individual Practice | ☐ Hospital-Based Physician |
| ☐ Corporation (Private) | ☐ Partnership | ☐ Group Practice |
| ☐ Health Maintenance Organization | ☐ Profit | ☐ Non-Profit |

15. If group practice, Number of Providers in Group (specify provider type):

_____

-1-

## PROVIDER INFORMATION (MAP-344)

16. If group practice, number of providers in group (specify provider type): _____

17. If corporation, name, address, and telephone number of corporate office: _____

Telephone No: _____

Name and address of officers:

_____

18. If partnership, name and address of partners: _____

19. National Pharmacy No. (If applicable): _____
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):
1st _____ Date _____
2nd _____ Date _____

21. Name of Clinic(s) in which Provider is a member:
1st _____
2nd _____
3rd _____
4th _____

22. Control of Medical Facility:
___ Federal ___ State ___ County ___ City
___ Charitable or religious
___ Proprietary (Privately-owned) ___ Other

2

## PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

16. If corporation, name, address and telephone number of Home Office:

Name: _____

Address: _____

_____

Telephone Number: _____

Name and Address of Officers:

_____

_____

_____

_____

_____

17. If Partnership, name and address of Partners:

_____

_____

_____

_____

_____

18. National Pharmacy Number (If Applicable): _____
(Seven-digit number assigned by National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st _____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

-2-

NEW FORM



## PROVIDER INFORMATION (MAP-344)

23. Fiscal Year End: _____

24. Administrator : _____ Telephone No. _____

25. Assistant Admin: _____ Telephone No. _____

26. Controller: _____ Telephone No. _____

27. Independent Accountant or CPA: _____
Telephone No. _____

28. If sole proprietorship, name, address, and telephone number of owner:
_____
_____

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board:
_____

Member: _____

Member: _____

30. Management Firm (If applicable):
_____

31. Lessor (If applicable):
_____

32. Distribution of beds in facility:

| | Total Licensed Beds | Total Kentucky Medicaid Certified Beds |
|---|---|---|
| Acute Care Hospital | _____ | _____ |
| Psychiatric Hospital | _____ | _____ |
| Nursing Facility | _____ | _____ |
| MR/DD | _____ | _____ |

33. NF or MR/DD owners with 5% or more ownership:

| Name | Address | % of Ownership |
|---|---|---|
| | | |
| | | |
| | | |

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Form



CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



## PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

21. Physician/Professional Specialty Certification Board:

1st _____ Date: _____

2nd _____ Date: _____

3rd _____ Date: _____

22. Name of Clinic(s) in which Provider is a Member:

1st _____

2nd _____

3rd _____

4th _____

23. Control of Medical Facility:

☐ Federal ☐ State ☒ County ☐ City ☐ Charitable or Religious

☐ Proprietary (Privately owned) ☐ Other _____

24. Fiscal Year End: _____

25. Administrator: _____ Telephone No. _____

26. Assistant Administrator: _____ Telephone No. _____

27. Controller: _____ Telephone No. _____

28. Independent Accountant or CPA: _____ Telephone No. _____

29. If sole proprietorship, name, address, and telephone number of owner:

Name: _____

Address: _____

Telephone No. _____

30. If facility is government owned, list names and addresses of board members:

| | Name | Address |
|---|---|---|
| President or Chairman of Board: | | |
| Member: | | |
| Member: | | |
| Member: | | |
| Member: | | |

NEW FORM



## PROVIDER INFORMATION (MAP-344)

34. Institutional Review Committee Members (If applicable):

_____

_____

35. Providers of Transportation Services:
Number of Ambulances in Operation:____
Number of Wheelchair Vans in Operation: ___
Basic Rate $_____ (Includes up to ___ miles)
Per Mile $_____ Oxygen $_____
Extra Patient $_____ Other $_____

36. Has this application been completed as the result of a change of ownership of a previously enrolled Medicaid provider? ___ yes ___ no

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____

Name: _____

Title: _____

Return all enrollment forms, changes and inquiries to:

Medicaid-Provider Enrollment
Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY
License Number Verified through _____ (Enter Code)

Comments: _____

_____

Date: _____ Staff: _____

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OLD FORM



CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



## PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 02/85)

31. Management Firm (If Applicable):

Name: _____

Address: _____

32. Lessor (If Applicable):

Name: _____

Address: _____

33. Distribution of Beds in Facility (Complete for all levels of care):

| | Total Licensed Beds | Total Title XIX Certified Beds |
|---|---|---|
| Hospital Acute Care | | |
| Hospital Psychiatric | | |
| Hospital TB/Upper Respiratory Disease | | |
| Skilled Nursing Facility | | |
| Intermediate Care Facility | | |
| ICF/MR/DD | | |
| Personal Care Facility | | |

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownership:

| Name | Address | Percent of Ownership |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

OLD FORM



CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



## PROVIDER INFORMATION (MAP-344)

35. Institutional Review Committee Members (If Applicable):

_____

_____

_____

_____

_____

36. Providers of Transportation Services:

No. of Ambulances in Operation:____ No. of Wheelchair Vans in Operation:____

Total No. of Employees:_____ (Enclose list of names, ages, experience & Training.)

Current Rates:

A. Basic Rate $_____ (Includes up to _____ miles.)

B. Per Mile $_____

C. Oxygen $_____ E. Other

D. Extra Patient $_____ _____ $_____

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license boards or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medical Assistance Program.

Signature:_____

Name:_____

Title:_____ Date:_____

INTER-OFFICE USE ONLY

License Number Verified through_____(Enter Code)

Comments:_____

_____

Date:_____ Staff:_____

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NEW FORM

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



## THIRD PARTY LIABILITY PROVIDER LEAD FORM

(REV. 7/91)

THIRD PARTY LIABILITY
LEAD FORM

Recipient Name : _____ MAID #_____

Date of Birth : _____Address:_____

Date of Service : _____ To:_____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company:_____

Address :_____

Policy #: _____ Start Date: _____ End Date:_____

Date Filed with Carrier : _____

Provider Name : _____ Provider #: _____

Comments: _____

_____

_____

_____

_____

_____

Signature:_____ Date:_____

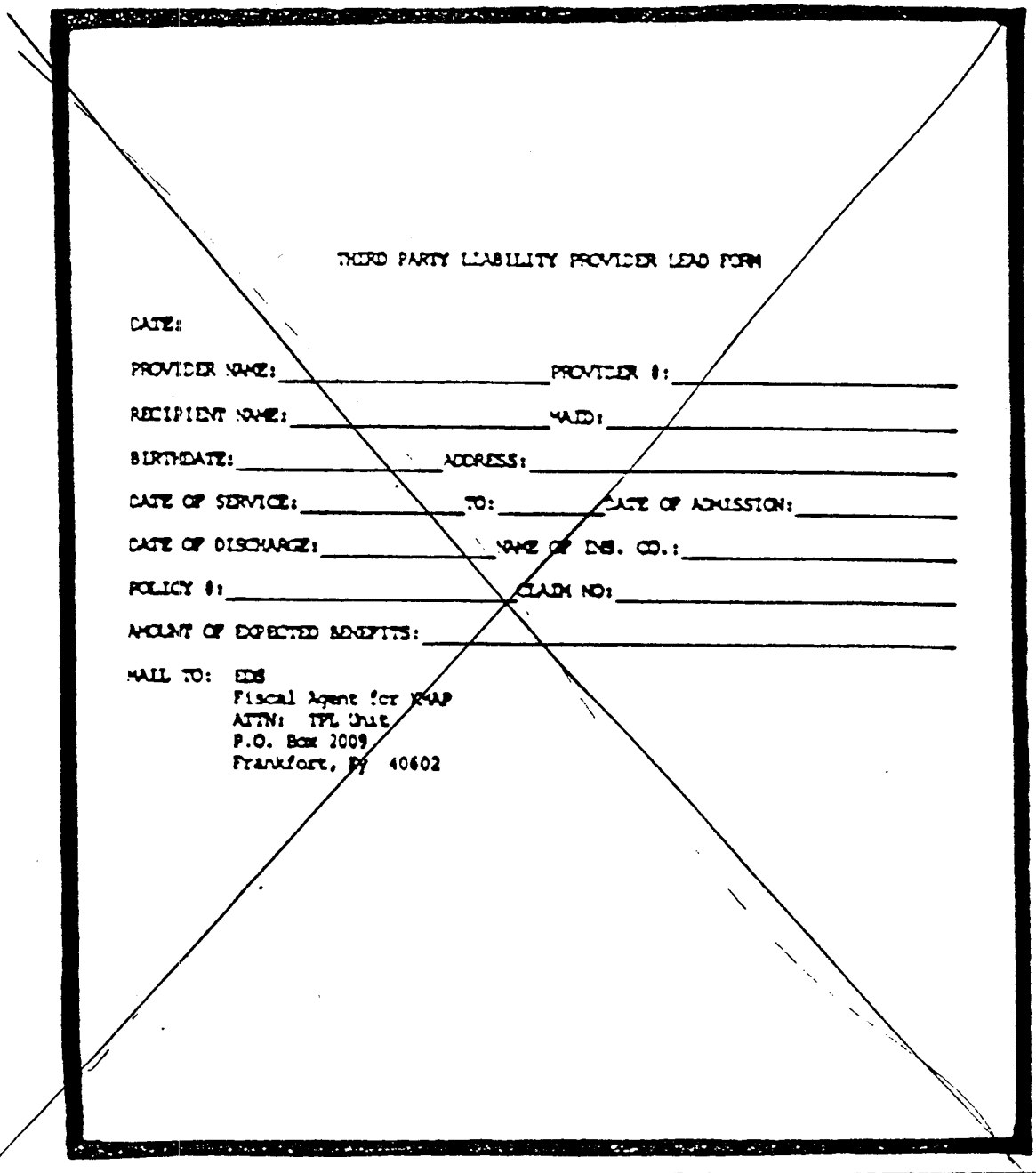
OLD
FORM



[CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



## THIRD PARTY LIABILITY PROVIDER LEAD FORM



THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE:

PROVIDER NAME:_____ PROVIDER #:_____

RECIPIENT NAME:_____ MAID:_____

BIRTHDATE:_____ ADDRESS:_____

DATE OF SERVICE:_____ TO:_____ DATE OF ADMISSION:_____

DATE OF DISCHARGE:_____ NAME OF INS. CO.:_____

POLICY #:_____ CLAIM NO:_____

AMOUNT OF EXPECTED BENEFITS:_____

MAIL TO: EDS
Fiscal Agent for KMAP
ATTN: TPL Unit
P.O. Box 2009
Frankfort, KY 40602

NEW FORM

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



## CERTIFICATION OF CONDITIONS MET (MAP-346)

MAP-346
(7/92)

KENTUCKY MEDICAID PROGRAM
CERTIFICATION OF CONDITIONS MET
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the Listed licensed medical professionals has entered into financial arrangements with _____
(FACILITY NAME)

_____, _____, for the purpose of providing
(CITY) (STATE)
his/her services to patients of this facility, and that currently on file in this facility is a Statement of Authorization (MAP-347) executed by each of these individuals which authorizes payment by the Kentucy Medicaid Program to _____ for services provided to eligible Kentucky Medicaid
(FACILITY)
Program recipients.

| NAME | PROFESSIONAL'S MEDICARE NUMBER | PROFESSIONAL'S LICENSE NUMBER | SPECIALTY | DATE OF FACILITY EMPLOYMENT |
|---|---|---|---|---|

SIGNATURE: _____

NAME: _____

DATE: _____

KENTUCKY MEDICAID
Provider#: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

OLD FORM



## CERTIFICATION OF CONDITIONS MET (MAP-346)

MAP-346
(8/82)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
CERTIFICATION OF CONDITIONS MET
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the following named licensed medical professionals is currently entered into financial arrangements with _____ (Facility Name) _____ (City) _____ (State), for the purpose of rendering his/her special services to patients of this facility, and that currently on file in this care center is a Statement of Authorization executed by each of these individuals which authorizes payment by the KMAP to the _____ (Facility Name) for services rendered eligible Program beneficiaries.

| NAME | LICENSE NUMBER | POSITION (Physician, Psychiatrist, etc.) | DATE OF CENTER EMPLOYMENT |
|---|---|---|---|

Signed _____
Facility Administrator

## CODING ADDENDUM

| INPATIENT REVENUE CODES | DESCRIPTION |
|---|---|
| 423 | Group Rate |
| 424 | Evaluation or Re-Evaluation |
| 440 | Speech Therapy, General |
| 441 | Visit Charge |
| 442 | Hourly Charge |
| 443 | Group Rate |
| 444 | Evaluation or Re-Evaluation |
| 450 | Emergency Room, General (For Services provided prior to June 1, 1991) |
| 460 | Pulmonary Function |
| 470 | Audiology, General |
| 472 | Treatment |
| 480 | Cardiology, General |
| 481 | Cardiac Cath Lab |
| 482 | Stress Test |
| 610 | MRI, General |
| 611 | Brain (including Brainstem) |
| 612 | Spinal Cord (including Spine) |
| 621 | Supplies Incident to Radiology |
| 622 | Supplies Incident to other Diagnostic Services |
| 634 | Erythropoietin (EPO) Less than 10,000 Units |
| 635 | Erythropoietin (EPO) 10,000 or More Units |
| 636 | Erythropoietin (EPO) Drug Requiring Detailed Coding |
| 700 | Cast Room, General |
| 710 | Recovery Room, General |
| 720 | Labor/Delivery Room, General |
| 721 | Labor |
| 722 | Delivery |
| 723 | Circumcision |
| 724 | Birthing Center (For services provided prior to June 1, 1991). |
| 730 | EKG/ECG, General |
| 731 | Holter Monitor |
| 732 | Telemetry (Includes fetal monitoring) |
| 740 | EEG, General |
| 750 | Gastro-Intestinal Services, General |
| 760 | Observation Room, General (For services provided prior to June 1, 1991). |

CODING ADDENDUM

| OUTPATIENT REVENUE CODES | DESCRIPTION |
|---|---|
| 424 | Physical Therapy, Evaluation or Re-Evaluation |
| 440 | Speech-Language Pathology, General |
| 441 | Speech-Language Path. - Visit Charge |
| 442 | Speech-Language Path. - Hourly Charge |
| 443 | Speech-Language Path. - Group Rates |
| 444 | Speech-Language Path. - Evaluation or Re-Evaluation |
| 450 | Emergency Room |
| 460 | Pulmonary Function |
| 470 | Audiology, General |
| 471 | Audiology, Diagnostic |
| 472 | Audiology, Treatment |
| 480 | Cardiology, General |
| 481 | Cardic Cath, Lab |
| 482 | Stress Test |
| 510 | Clinic, General |
| 512 | Dental Clinic |
| 610 | MRI, General (Effective Date 11/25/85) |
| 611 | MRI, Brain (Effective Date 11/25/85) |
| 612 | MRI, Spine (Effective Date 11/25/85) |
| 621 | Supplies Incident to Radiology |
| 622 | Supplies Incident to Other Diagnostic Services |
| 634 | Erythropoietin (EPO) Less Than 10,000 Units |
| 635 | Erythropoietin (EPO) 10,000 or more Units |
| 636 | Erythropoietin (EPO) Drug Requiring Detailed Coding |
| 700 | Cast Room |
| 710 | Recovery Room |
| 720 | Labor Room/Delivery, General |
| 721 | Labor Room |
| 722 | Delivery Room |
| 723 | Circumcision |
| 724 | Birthing Center |
| 730 | EKG/ECG (Electrocardiogram), General |
| 731 | Holter Monitor |
| 732 | Telemetry (Incl Fetal Monitoring) |
| 740 | EEG (Electrocencephalogram), General |
| 750 | Gastro-Intestinal Service General |

NEW FORM



CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES



# ADVANCE DIRECTIVE LAW

## DESCRIPTION OF KENTUCKY

## ADVANCE DIRECTIVE LAW

In compliance with the mandate for Kentucky to develop a written description of its statutory and case law concerning advance directives, this office presents such a description below, which is based on statutory law, there being no case law which has specifically addressed the issue.

## KENTUCKY LAW ON ADVANCE DIRECTIVES FOR MEDICAL DECISIONS

### THE KENTUCKY LIVING WILL ACT

The 1990 session of the Kentucky General Assembly passed and the Governor signed into law House Bill No 113, known as the Kentucky Living Will Act, which is codified at KRS 311.622-644 and now sanctions the right of adult Kentuckians of sound mind to execute a written declaration which would allow life-prolonging treatments to be withheld or withdrawn in the event they become terminally ill and can no longer participate in making decisions about their medical care. The living will must be signed by the declarant in the presence of two subscribing witnesses who must not be blood relatives who would be beneficiaries of the declarant, beneficiaries of the declarant under the descent and distribution statutes of Kentucky, an employee of a health care facility in which the declarant is a patient, an attending physician of the declarant, or any person directly financially responsible for the declarant's health care. The living will must be notarized.

-1-

## ADVANCE DIRECTIVE LAW

Two physicians, one of whom being the patient's attending physician, would have to certify that the declarant's condition was terminal before the living will could be implemented. The living will would not allow for the withholding or withdrawal of food or water, or medication or medical procedures deemed necessary to alleviate pain, and it would not apply to pregnant women.

### THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session of the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-986 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor.

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

-2-

## ADVANCE DIRECTIVE LAW

### DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity of the person who executed the durable power of attorney.

PREPARED BY:

THE CABINET FOR HUMAN RESOURCES
OFFICE OF GENERAL COUNSEL
APRIL 22, 1991

-3-

## ADVANCE DIRECTIVE LAW

# *Living Will Declaration*

Declaration made this _____ day of _____(month), _____ (year).

I, _____, willfully and voluntarily make known my desire that my dying all not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending and one (1) other physician in their discretion, have determined such condition is incurable and irreversible and will result in death within a relatively short time, and where the application of life-prolonging treatment would serve only to artificially prolong the dying process, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain or for nutrition or hydration.

In the absence of my ability to give directions regarding the use of such life-prolonging treatment, it is my intention that this declaration shall be honored by my attending physician and my family as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

State of Kentucky )
)Sct.
County of _____ )

Before me, the undersigned authority, on this day personally appeared _____ and _____, Living Will Declarant, and _____ and _____, known to me to be witnesses whose names are each signed to the foregoing instrument, and all these persons being first duly sworn, _____, Living Will Declarant, declared to me and to the witnesses in my presence that the instrument is the Living Will Declaration of the declarant and that the declarant has willingly signed and that such declarant executed it as a free and voluntary act for the purposes therein expressed; and each of the witnesses stated to me, in the presence and hearing of the Living Will Declarant, that the declarant signed the declaration as witnessed, and to the best of such witnesses' knowledge, the Living Will Declarant was eighteen(18) years of age or over, of sound mind and under no constraint or undue influence.

_____
Living Will Declarant

_____
Witness

_____
Address

_____
Witness

_____
Address

Subscribed, sworn to and acknowledged before me by _____, Living Will Declarant, and subscribed and sworn before me by _____ and _____ witnesses, on this the _____(day) of _____(month)_____(year).

_____
Notary Public State at Large

_____
Date my commission expires

# ADVANCE DIRECTIVE LAW

## DESIGNATION OF HEALTH CARE SURROGATE

I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S) TO MAKE ANY HEALTH CARE DECISIONS FOR ME WHEN I NO LONGER HAVE DECISIONAL CAPACITY. IF _____ REFUSES OR IS NOT ABLE TO ACT FOR ME, I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S).

ANY PRIOR DESIGNATION IS REVOKED.

SIGNED THIS _____ DAY OF _____, 19____

_____
SIGNATURE AND ADDRESS OF THE GRANTOR

IN OUR JOINT PRESENCE, THE GRANTOR, WHO IS OF SOUND MIND AND EIGHTEEN YEARS OF AGE, OR OLDER, VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE DATED AND SIGNED FOR THE GRANTOR.

_____
SIGNATURE AND ADDRESS OF WITNESS

_____
SIGNATURE AND ADDRESS OF WITNESS

COMMONWEALTH OF KENTUCKY

_____ COUNTY

BEFORE ME, THE UNDERSIGNED AUTHORITY, CAME THE GRANTOR WHO IS OF SOUND MIND AND EIGHTEEN (18) YEARS OF AGE, OR OLDER, AND ACKNOWLEDGED THAT HE VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE SIGNED AND DATED AS ABOVE.

DONE THIS _____ DAY OF _____, 19____

_____
SIGNATURE OF NOTARY PUBLIC

DATE COMMISSION EXPIRES: _____

# ADVANCE DIRECTIVE

## ACKNOWLEDGMENT

NAME:_____ DATE OF BIRTH: _____

SOC. SEC.#:_____

PLEASE READ THE FOLLOWING FIVE STATEMENTS:

Place your initials after each statement.

1. I have been given written materials about my right to accept or refuse medical treatment. _____(Initialed)
2. I have been informed of my right to formulate advance directives. _____(Initialed)
3. I understand that I am not required to have an advance directive in order to receive medical treatment. _____(Initialed)
4. I understand that the terms of any advance directive that I have executed will be followed by my caregivers to the extent permitted by law. _____(Initialed)
5. I understand that I can change my mind at any time and that my decision will not result in the withholding of any benefits or medical services. _____(Initialed)

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ I HAVE EXECUTED AN ADVANCE DIRECTIVE.

☐ I HAVE NOT EXECUTED AN ADVANCE DIRECTIVE.

_____ DATE: _____
Patient/Guardian

_____ DATE: _____
Health Care Provider Representative

# ADVANCE DIRECTIVE LAW

## PATIENT SELF-DETERMINATION PROTOCOL FOR CERTIFIED HEALTH CARE PROVIDERS

1. The Certified Health Care Provider shall inform all adult patients, in writing and orally, of information under Kentucky Law concerning their right to make decisions relative to their medical care.

2. The Certified Health Care Provider shall present each adult patient with a written copy of the agency's policy concerning implementation of their rights.

3. The Certified Health Care Provider shall not condition the provision of care or otherwise discriminate against any patient based on whether the patient has executed an advance directive.

4. The Certified Health Care Provider shall document in the patient's medical record whether or not the patient has executed an advance directive.

5. The Certified Health Care Provider shall ensure compliance with requirements of Kentucky Law concerning advance directives.

6. The Certified Health Care Provider shall educate all agency staff and the general public concerning advance directives.

# ADVANCE DIRECTIVE LAW

## PATIENT SELF-DETERMINATION

Policy:

Advise all adult patients (a person eighteen [18] years of age or older and who is of sound mind) of their rights concerning advance directives. (According to provider type, i.e., admission, start of care, etc.)

Purpose:

1. To assure individuals understand they have the right to:

    a. Accept or refuse medical or surgical treatment; and

    b. Formulate advance directives.

Procedure:

Each Certified Health Care Provider shall:

1. Designate a person or persons responsible for informing adult patients of their right to make decisions concerning their medical care.

2. Distribute to each adult patient the following information:

    a. The Cabinet for Human Resources' description of Kentucky Laws on Advance Directives.

    b. Agency policy regarding implementation of advance directives.

NOTE: Recommend distribution of additional information to assist patients and/or staff in understanding advance directives. The following materials are acceptable:

"Advance Directives Issues and Answers"
Hospice of the Bluegrass

"Advance Directives, Living Will, Health Care Surrogate, Durable Power of Attorney" Video
Hospice of the Bluegrass

"About Advance Medical Directives"
Channing Bete Co., Inc.

"Living Will"
Division of Aging Services

PATIENT SELF-DETERMINATION (Continued)

"Planning For Difficult Times - Tomorrow's Choices"
"Planning For Difficult Times - A Matter of Choice"
American Association of Retired Persons

3. Maintain *Living Will* and *Designation of Health Care Surrogate* documents for distribution to adult patients upon request.

4. Documentation supporting compliance with the requirements regarding non-discriminatory care shall be incorporated into the Quality Assurance process.

5. Documentation supporting the patient's decision to formulate an advance directive shall be included in the medical record. (Recommend use of attached *Advance Directive Acknowledgment* Form.) A process shall be developed to assure appropriate staff are advised of the patient's directive.

6. Documentation supporting all aspects of the staff and general public education campaign shall be recorded by appropriate personnel.

7. Stipulate by policy, family members or guardians will be provided with information regarding advance directives when the patient is comatose or otherwise incapacitated and unable to receive the information. Once he or she is no longer incapacitated the information must be provided directly to the adult patient.

## HEALTH INSURANCE CLAIM FORM (HCFA-1500 Rev. 12/90)

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE